

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4719	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/18/2012
NAME OF PROVIDER OR SUPPLIER WEST HILLS HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 6801 MIDDLEBROOK PIKE KNOXVILLE, TN 37919		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments Investigation of Complaint (C/O) numbers: TN29763, TN29218, TN28817, TN29040, and TN28711, was conducted May 14-18, 2012. No deficiencies were cited related to the complaints under 1200-8-6 Standards for Nursing Homes.		N 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

LG2N11

If continuation sheet 1 of 1